STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		(X2) MULTIPLE CC A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/31/2022	
	155199	B. WING		10/31/2023	
NAME OF P	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP COD JNION ST		
MAPLE F	PARK VILLAGE		FIELD, IN 46074		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
E 0000	REGULATORT OR ESC IDENTIFTING INFORMATION	TAG		DATE	
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/31/23 Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390 At this Emergency Preparedness survey, Maple Park Village was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 106 certified beds. At the time of the survey, the census was 80.	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencie of any violation of regulation. This provider respectfully requitate the 2567 plan of correction considered the letter of credibility allegation and requests desk review (paper compliance) on after 11/16/23.	t s forth s, or ests n be	
	Quality Review completed on 11/03/23				
K 0000					
Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/31/23 Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390 At this Life Safety Code survey, Maple Park Village was found not in compliance with		The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencie of any violation of regulation. This provider respectfully requitate the 2567 plan of correction considered the letter of credible allegation and requests desk review (paper compliance) on after 11/16/23.	t s forth s, or lests n be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Anthony Link Executive Director 11/15/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: SLYS21 Facility ID: 000106 If continuation sheet Page 1 of 11

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155199	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/31/2023
MAPLE F	PROVIDER OR SUPPLIER		776 N U	ADDRESS, CITY, STATE, ZIP COD JNION ST FIELD, IN 46074	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Life Safety from Fin National Fire Protect Life Safety Code (L. Health Care Occupation This one-story facil Type V (111) const. The facility has a find etection in the correction corridors, and batter all resident sleeping capacity of 106 and of this survey. All areas where resident services were sprinkled and services were sprinkled sused for facilities.	the and the 2012 edition of the etion Association (NFPA) 101, and a census of 80 at the time. The and the 2012 edition of the etion Association (NFPA) 101, and a census of 80 at the time. The analysis of the etion of the etion and was fully sprinkled. The alarm system with smoke etions, spaces open to the ety powered smoke detectors in a rooms. The facility has a had a census of 80 at the time.			
K 0355 SS=E Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to ensure 1 of in the facility were accordance with NF Fire Extinguishers, states Fire extinguishers located where they immediately available.	nguishers guishers are selected, d, and maintained in IFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility 525 portable fire extinguishers	K 0355	K 355 Fire Extinguishers 1.What corrective action(s) will be taken for those residents found to have beer affected by the deficient practice? The Hoyer lift was moved away from the fire extinguisher. None of the 24 residents, 4 staff, and 2 visitor	n

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SLYS21 Facility ID: 000106

If continuation sheet

Page 2 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	O1 COMPLETED		
		155199	B. W	NG		10/31/2023	
	ROVIDER OR SUPPLIER		•	776 N L	ADDRESS, CITY, STATE, ZIP COD JNION ST FIELD, IN 46074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	lE	DATE
	paths of travel, incl	uding exits from areas. This			showed injury due to the allege	ed	
	deficient practice co	ould affect as many as 24			deficient practice.		
	residents, 4 staff an	d 2 visitors.			·		
	Findings include: Based on observation facility with the Adp.m. the ABC portathe corridor between #211 was obstructed interview at the time Administrator acknowledges and the corridor Hoyer lift, and not a case of a fire situation.	ons made during a tour of the ministrator, on 10/31/23 at 1:16 ble fire extinguisher located in n resident rooms #209 and d by Hoyer lift. Based on e of observation, the owledged the fire extinguisher dor, was obstructed by the readily accessible for use in on.			1.How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Any instances of fire extinguishers being obstructed will be addressed immediately. All stawere inserviced and educated ensuring fire extinguishers are obstructed. 1.What measures will be puinto place or what systemic changes will you make to ensure that deficient practice does not recur? Staff were inserviced and educated on ensuring fire extinguishers are obstructed. Maintenance supervisor will conduct rounds daily to ensure fire extinguisher are un obstructed.	aff on un ut	
					1.How the corrective action will be monitored to ensure t deficient practice will not recur, i.e. what quality assurance program will be printo place? Facility will used k 355 CQl audit tool. Observation will be 5 times per week for 4 weeks, and then weekly for 5	he ut	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SLYS21 Facility ID: 000106

If continuation sheet Page 3 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/20/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. B		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/31/2023	
	ROVIDER OR SUPPLIER		776 N U	ADDRESS, CITY, STATE, ZIP COD JNION ST FIELD, IN 46074	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DATE
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting of than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containir combustible mate hardware. Roller la CMS regulation. Ta apply to auxiliary se flammable or com Clearance betwee covering is not exc doors complying verified with a ce the door closed we applied. There is closing of the door release when the	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in gire for at least 20 fully sprinklered smoke is only required to resist the example. Corridor doors and doors in glammable or rials have positive latching atches are prohibited by these requirements do not spaces that do not contain	TAG	months. If 90% compliance achieved, an action plan we developed. After six month QAPI committee will re-even the continued need for the Deficiency in this practice were sult in disciplinary action and including termination or responsible employee. 5. Date of Compliance 11/16/2023	e is not rill be ths the raluate audit. will up to of the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SLYS21 Facility ID: 000106

If continuation sheet Page 4 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 COMPLETED			
		155199	B. WI	ING		10/31	/2023
	PROVIDER OR SUPPLIER		•	776 N L	ADDRESS, CITY, STATE, ZIP COD JNION ST FIELD, IN 46074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
	unlimited height a meeting 19.3.6.3.4 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratio devices, etc. Based on observation failed to ensure 1 or doors to the corrido latch into the door frould affect as man visitors. Findings include: Based on observation facility with the Adp.m., the corridor defailed to close and I interview at the tim Administrator acknowledges are interviewed to the door from the door as soon the door as soon	re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments ctions in area or fire are or frames in window. Parts 403, 418, 460, 482, 483 and and interview, the facility of 56 sets of resident room are would close completely and frame. This deficient practice are y as 24 residents, 4 staff, and 2 and interview, the facility of 56 sets of resident room are would close completely and frame. This deficient practice are y as 24 residents, 4 staff, and 2 and frame adding that he would completely and frame adding that he would completely co	K 0.		K363 Corridor- Doors 1.What corrective action(s) where taken for those residents found to have been affected the deficient practice? The clatch and striker plate were adjusted to ensure the door latched properly into the frame None of the 24 residents, 4 strand 2 visitors showed injury dithe alleged deficient practice. 2.How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Any instances of resident room do to the corridor that don't close completely and latch into the frame will be addressed	by door e. aff, ue to al	11/16/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SLYS21

Facility ID: 000106

If continuation sheet

Page 5 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/20/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155199	B. W	ING		10/31/	2023
NAME OF D	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP COD		
					JNION ST		
MAPLE F	PARK VILLAGE			WESTF	FIELD, IN 46074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-19(b)				immediately. All staff were		
					inserviced and educated on	f	
					ensuring that any instances or resident room doors to the co		
					that don't close completely an		
					latch into the frame will be	-	
					reported to maintenance pers	onnel	
					or administration immediately		
					_		
					3.What measures will be put		
					into place or what systemic		
					changes will you make to		
					ensure that deficient practic		
					does not recur? All staff were	9	
					inserviced and educated on	f	
					ensuring that any instances or resident room doors to the co		
					that don't close completely an		
					latch into the frame will be	u	
					reported to maintenance pers	onal	
					or administration immediately		
					Maintenance supervisor will		
					conduct audits weekly then		
					monthly to ensure that all resi	dent	
					room doors to the corridor clo		
					completely and latch into the		
					frame .		
					4.How the corrective action(e)	
					will be monitored to ensure	•	
					deficient practice will not		
					recur, i.e. what quality		
					assurance program will be p	ut	
					into place? Facility will used I		
					363 CQI audit tool. An audit of		
					resident room doors to the co		
					will be weekly for 4 weeks, an	d	
					then monthly for 5 months. If	90%	
					compliance is not achieved, a	n	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SLYS21

Facility ID: 000106

106

If continuation sheet Page 6 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/20/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155199	A. BUILDING B. WING	01	COMPLETED 10/31/2023
	PROVIDER OR SUPPLIER PARK VILLAGE		776 N I	ADDRESS, CITY, STATE, ZIP COD UNION ST FIELD, IN 46074	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
				action plan will be develope. After six months the QAPI committee will re-evaluate the continued need for the audit Deficiency in this practice we result in disciplinary action used including termination of responsible employee. 5.Date of Compliance 11/16/2023	ne ill ip to
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartmiquids, combustiblused or stored and location, and such signs that read NC posted with the int smoking. (2) In health care compartmently placed secondary signs was moking shall not (3) Smoking by paresponsible shall be (4) The requirement apply where the passupervision. (5) Ashtrays of not safe design shall be where smoking is	ons ons shall be adopted and less than the following be prohibited in any room, ment where flammable to gases, or oxygen is at in any other hazardous area shall be posted with the osmoking of shall be the ernational symbol for no occupancies where the dand signs are that all major entrances, with language that prohibits the required. It is the prohibited of the prohibited of the prohibited of the prohibited of the provided in all areas			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SLYS21

Facility ID: 000106

If continuation sheet

Page 7 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLET				
		155199	B. WING 10/31/2023				2023
	ROVIDER OR SUPPLIER			776 N L	ADDRESS, CITY, STATE, ZIP COD JNION ST FIELD, IN 46074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	devices into which shall be readily av smoking is permitted 18.7.4, 19.7.4 Based on observation failed to ensure 1 of permitted for staff with 19.7.4. LSC 19 noncombustible maprovided in all areas Metal containers with into which ashtrays readily available to permitted. This defin only as residents are outside of the facility. Findings include: Based on observation facility with the Adp.m., there were approximated in with dry let the smoking area. Both observation, the cigarette butts in immediately adjaced area adding that he as soon as he could.	ashtrays can be emptied allable to all areas where ted. on and interview, the facility of 1 area where smoking was was maintained in accordance 0.7.4 requires ashtrays of terial and safe design shall be swhere smoking is permitted. the aself-closing cover devices can be emptied shall be all areas were smoking is cient practice could affect staff to enot allowed to smoke in or try. ons made during a tour of the ministrator, on 10/31/23 at 1:04 proximately 30 cigarette butts eaves immediately adjacent to tased on interview at the time Administrator acknowledged nixed in with the dry leaves int to and around the smoking would have them taken care of a discussed at the exit	K 0	TAG	K741- Smoking Regulations 1. What corrective action(s) we taken for those residents found to have been affected the deficient practice? This deficient practice could affect only as residents are not allow to smoke in or outside of the facility. The cigarette butts are leaves were swept up in the an leaves we	vill by staff ved al staff on re etal	
					ashtray. Housekeeping super will conduct daily audits 5 time per week and then weekly to		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SLYS21

Facility ID: 000106

If continuation sheet

Page 8 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/20/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155199	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/31/2023
	PROVIDER OR SUPPLIEF	2	776 N	ADDRESS, CITY, STATE, ZIP CO UNION ST FIELD, IN 46074	OD
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) ROULD BE PPROPRIATE COMPLETION DATE
				ensure that cigarette budisposed of in an approach ashtrays.	
				4.How the corrective a will be monitored to e deficient practice will recur, i.e. what quality assurance program w into place? Facility will 741 CQI audit tool. An to ensure that cigarette disposed of in an approashtrays will be used 5 week for 4 weeks, and weekly for 5 months. It compliance is not achie action plan will be deve After six months the QA committee will re-evalu continued need for the Deficiency in this practi result in disciplinary act and including termination responsible employee. 5.Date of Compliance 11/16/2023	nsure the not iill be put I used K audit tool butts are byed metal times per I then If 90% beved, an beloped. API late the audit. ice will tion up to
K 0911 SS=E Bldg. 01	Chapter 6 Electric that are not addre K-Tags, but are do along with the app	s - Other RKS section any NFPA 99 al Systems requirements ssed by the provided eficient. This information, blicable Life Safety Code or tation, should be included			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SLYS21 Facility ID: 000106

If continuation sheet

Page 9 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		r í	JILDING	onstruction 01	(X3) DATE COMPL 10/31/	ETED	
	PROVIDER OR SUPPLIER			776 N L	ADDRESS, CITY, STATE, ZIP COD JNION ST FIELD, IN 46074		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	failed to ensure accomaintained in enclosure apparatus in 1 of 7 of Care Facilities Code states electrical instruction with NFPA 70, Natical for equipment operaless and likely to reservicing, or mainter comply with the dirand (3). Distances aparts if such parts are enclosure front or of Article 110.26(B) strequired by this secretary as 24 resident. Findings include: Based on observation facility with the Adp.m., the electrical president rooms #204 obstructed from accestored in the corridor time of the observation acknowledged the Finding in front of electrical panel be and #206.	and and interview, the facility less and working space was sures housing electrical corridors. NFPA 99, Health e., 2012 Edition, Section 6.3.2.1 allation shall be in accordance fonal Electric Code. NFPA 70, the 110.26 states working space atting at 600 volts, nominal, or quire examination, adjustment, nance while energized shall the measured from the live are exposed or from the pening if such are enclosed. The transition of the measured from the principal form the gradient of the working space and the states of the working space and the states of the states of the transition of the ministrator, on 10/31/23 at 1:10 cannel in the corridor between the and #206 was completely less by a Hoyer lift being the states of the working space in front the transition of the working space in front the transition of the working space in front the working space in front the working space in front etween resident rooms #204	K 0	911	K911- Electrical Systems- Oth 1. What corrective action(s) who be taken for those residents found to have been affected the deficient practice? The Hoyer Lift was moved away from the electrical panel. None of the 24 residents, 4 staff, and 2 vis showed injury due to the alleg deficient practice. 2. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Any instances of electrical panels being obstructed will be addressed immediately. All st were inserviced and educated ensuring electrical panels are obstructed. 3. What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur? Staff were inserviced and educated on ensuring electrical panels are obstructed. Maintenance supervisor will conduct rounds daily to ensure electrical panel are un obstructed.	vill by om ne sitors ed al	11/16/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SLYS21 Facility ID: 000106

If continuation sheet

Page 10 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/20/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155199		A. Bl	(X2) MULTIPLE CONSTRUCTION (X3) DATE : A. BUILDING 01 COMPL B. WING 10/31/		ETED		
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE			776 N L	ADDRESS, CITY, STATE, ZIP COD JNION ST FIELD, IN 46074			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
					4.How the corrective action (swill be monitored to ensure to deficient practice will not recur, i.e. what quality assurance program will be pinto place? Facility will used to 911 CQI audit tool. Observative will be 5 times per week for 4 weeks, and then weekly for 5 months. If 90% compliance is achieved, an action plan will be developed. After six months QAPI committee will re-evaluate the continued need for the audit Deficiency in this practice will result in disciplinary action up and including termination of the responsible employee. 5.Date of Compliance 11/16/2023	ut Cons not e the ate dit.	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: SLYS21 Facility ID: 000106 If continuation sheet Page 11 of 11